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NOT TO BE PUBLISHED IN THE OFFICIAL REPORTS

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

SECOND APPELLATE DISTRICT

DIVISION SEVEN

DEVELOPMENT SPECIALTY PROJECTS, INC., Plaintiff, Cross-defendant and Appellant, v. THE DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS, Defendant, Cross-complainant and Respondent.	B251217 (Los Angeles County Super. Ct. No. TC023187)

APPEAL from a judgment of the Superior Court of Los Angeles County, Lynn Olson and Ross M. Klein, Judges. Affirmed.

Law Office of Kent W. Easter and Kent W. Easter for Plaintiff, Cross-defendant and Appellant.

Kamala D. Harris, Attorney General, Kristin G. Hogue, Senior Assistant Attorney General, Elizabeth S. Angres and Paul F. Arentz, Deputy Attorneys General, for Defendant, Cross-complainant and Respondent.

Plaintiff Development Specialty Projects, Inc. (Provider) appeals from a judgment in favor of defendant, the Department of Alcohol and Drug Programs (Department). Following summary adjudication of issues on the complaint and summary judgment on the cross-complaint, judgment was entered against Provider on its third amended complaint and in favor of Department on its cross-complaint pursuant to stipulation. (*Norgart v. Upjohn Co.* (1999) 21 Cal.4th 383, 402.)

By its complaint, Provider sought to recover money it claimed it was owed for services it provided to Medi-Cal beneficiaries pursuant to its contract with Department. In the cross-complaint, Department sought to recover money it claimed it erroneously paid to Provider for those services.

On appeal, Provider contends the trial court erred in granting summary adjudication on the complaint and summary judgment on Department's cross-complaint, in that there are triable issues of material fact as to Department's obligations under the contract, Provider's liability for breach of contract, and Provider's affirmative defenses. We affirm.

FACTUAL BACKGROUND

A. *Summary of Dispute*

Department is a state agency that administers the provision of drug treatment services under Medi-Cal. Since at least fiscal year 2004-2005, Provider has contracted with Department to provide certain drug counseling and treatment services to minors. Provider rendered those services at specified public schools. Provider's services included: Naltrexone treatment, outpatient drug free treatment (both individual and group treatment), and Day Care Rehabilitative services (Day Care).[1] This dispute concerns only Day Care services. Pursuant to its contract with Department, after Provider renders

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[1] These services are sometimes referred to as "Day Care Habilitative" services.

a service, it submits a claim form to Department which contains the amount of service provided (measured in units of service) and a code indicating which type of service was provided. Department reimburses Provider for the services rendered and annually sends a Cost Report Settlement in which Department indicates any amount that is due back to Department for that fiscal year. The settlement of the final cost reports can be a lengthy process and typically takes about two years to resolve.

The contracts at issue here are for fiscal years 2006-2007 and 2007-2008 (Contract). At some point in 2008 Department determined that some payments for claims for Day Care services were not authorized under the Contract or state law and stopped reimbursing for those services. These disputed services were provided to minors under the Minor Consent program. Under Minor Consent, Provider could render certain services to minors without requiring the minors to provide family income or citizenship status information. Minor Consent services are state funded and no federal funds are used to reimburse providers for these services. Department contends that under the Contract and state law, allowable Day Care services provided under Minor Consent were limited to minors who were pregnant or post-partum, or Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible beneficiaries. EPSDT is a federally-mandated program under which the state must provide certain services, even if not otherwise within the scope of Medi-Cal. (42 U.S.C. § 1396d(r)(5).) Department contends that EPSDT services require the beneficiary to be fully Medi-Cal eligible, including meeting the family income and citizenship criteria. The state is able to draw down a federal share of funding for EPSDT services.

The Department stopped reimbursing for Day Care services under the Minor Consent category for minors who were not pregnant or post-partum, or shown to be EPSDT-eligible beneficiaries. The codes used by Provider in seeking reimbursement showed that the disputed Day Care services were not for pregnant or post-partum minors, and did not include a full Medi-Cal identification number or otherwise indicate that the minors were EPSDT-eligible.

Provider disagrees with Department on both the interpretation of the Contract and the interpretation of law. Further, Provider contends that Department breached the Contract by failing to give it 60 days notice after determining the services were not reimbursable, and that by paying Provider for a number of years for services which are now in dispute, Department is estopped from seeking reimbursement of moneys erroneously paid.

Before considering the contract claims, we examine the regulatory background governing Medi-Cal and Medicaid as necessary to resolution of the issues.

B. *Regulatory Background*

1. *Programs and Services*

a. *Drug Medi-Cal*

California provides drug treatment services to individuals through the Drug Medi-Cal Treatment Program, known as Drug Medi-Cal. (Welf. & Inst. Code, § 14124.20 et seq.) The services are administered pursuant to an interagency agreement between the California Department of Health Services (Health Services) and Department. (*Sobky v. Smoley* (E.D.Cal. 1994) 855 F.Supp. 1123, 1127.)

Department contracts with counties and with service providers to provide substance abuse disorder treatment services to Medi-Cal-eligible beneficiaries. In order for providers to receive reimbursement for their services, they must be certified under the Drug Medi-Cal program and have a contract with either a county or Department.

Health Services sets eligibility standards for Medi-Cal, including Drug Medi-Cal. Eligibility for Drug Medi-Cal may be full-scope, based on a family's eligibility for Medi-Cal, or it may be of limited scope under the Minor Consent program.

b. *Minor Consent*

Minor Consent is a Medi-Cal program for children under age 21, living with their parents, seeking a limited range of medical services. They can consent to receive these services without parental knowledge or consent and without regard to their families'

income or citizenship status. The services include treatment for sexual assault, family planning, pregnancy, mental health, and drug and alcohol abuse for persons age 12 and older. (Fam. Code, § 6929, subd. (b); Cal. Code Regs., tit. 22, § 50063.5.)

Minor Consent beneficiaries apply for a specific type of service. Once a child's eligibility is approved, the county issues the child a paper Medi-Cal card which is valid for one month. The card contains a Minor Consent services only identification number, normally a pseudo-Client Identification Number, but sometimes a Medi-Cal Eligibility Data System (MEDS) beneficiary identification number, to receive the specified services. MEDS contains information on Medi-Cal eligibility. Eligibility is determined by county welfare offices.

Each category of service has its own aid code. Code 7M is "[r]estricted to minors who are at least 12 years of age and limited to sexually transmitted diseases, drug and alcohol abuse, family planning, and sexual assault treatment." Code 7P covers the same services plus "outpatient mental health treatment and counseling." Code 7N is "[r]estricted to pregnant minors of any age, limited to pregnancy and pregnancy-related services." Code 7R is "[r]estricted to minors under age 12 and limited to family planning and sexual assault treatment."

The service provider is responsible for determining eligibility to receive services and entering the appropriate identification number and aid code on the claim form for reimbursement. Where applicable, the service provider makes the determination whether to use a Minor Consent beneficiary's Minor Consent services only identification number or full scope Medi-Cal identification number.

c. *EPSDT*

EPSDT is a federally-mandated Medicaid program, available under Medi-Cal to persons under the age of 21. Under EPSDT, the state pays for any medically necessary procedure or treatment to correct or ameliorate a defect, physical or mental illness, or condition, even if the services provided would not otherwise be available under Medi-Cal. (42 U.S.C. § 1396d; Cal. Code Regs., tit. 22, §§ 51184, 51242, 51340, 51532.)

EPSDT services are provided through the Child Health and Disability Prevention (Child Health) program. (Cal. Code Regs., tit. 22, § 51340, subd. (a), 51532; see Health & Saf. Code, §§ 104395, 124025-124110; Cal. Code Regs., tit. 17, § 6800 et seq.) Children participating in the Child Health program must have full-scope Medi-Cal eligibility or be eligible based on family income. Services under the Child Health program are not available based on Minor Consent eligibility because family involvement in the program is required.

The Child Health program has its own aid codes for its services. Aid codes 8U, 8V, 8W, 8X, and 8Y include EPSDT services.

d. *Day Care Services*

Day Care services include outpatient counseling and rehabilitation services, provided for at least three hours a day, three days a week, to persons with substance abuse diagnoses who are pregnant or post-partum and/or to EPSDT beneficiaries. (Welf. & Inst. Code, § 14132.905; Cal. Code Regs., tit. 22, § 51341, subd. (b)(6).)

2. *Billing Procedures*

Health Services handles billings for the Medi-Cal program, including Drug Medi-Cal. Billings for Drug Medi-Cal are processed under the Short-Doyle Mental Health Medi-Cal Program (Short-Doyle), which deals with alcohol and drug treatment services. Not all Medi-Cal drug and alcohol treatment programs are included within the purview of Short-Doyle. Only those services for which federal financial participation (Federal Participation) is available fall under Short-Doyle. Services under the Minor Consent program are ineligible for Federal Participation because there is no income or alien status verification done for the beneficiaries. These services are paid out of the State General Fund.

In order to be reimbursed for services, a provider submits its claims for reimbursement to Department, which then reports them to Health Services. Health Services verifies eligibility. The Short-Doyle system accesses the MEDS database to

determine eligibility and either approve or deny a claim. The Short-Doyle system will automatically deny claims for Minor Consent beneficiaries, because it only approves claims with Federal Participation.

Health Services prepares an explanation of benefits for each claim approved, denied, or suspended. Department then gives the explanation of benefits to the service provider.

C. *Provider's Provision of Day Care Services*

Provider provides substance abuse disorder treatment services to Medi-Cal eligible beneficiaries under Drug Medi-Cal. It contracts directly with Department. It is not directly enrolled in the Medi-Cal program as a provider.

Contract summaries for Minor Consent services appended to the Contract include a provider rate, proposed number of units of service, and budget for Day Care services. Under Provider's contracts with Department, the majority of the funds for these services were to come from the State General Fund. Under the Contract, Day Care services carried the highest reimbursement rate per unit of service.

D. *Denial of Provider's Claims*

1. *Provider receives reimbursement for Day Care services.*

Provider provided Day Care services to Minor Consent beneficiaries from 2004 through 2008. Reimbursement payments were sometimes delayed, and "[c]ost settlement reports were routinely two years late from 2004 to 2008."[2] In 2008, Susan King (King), a manager in Department's Fiscal Management and Accountability Branch, requested that McGuire resubmit $2 million in Day Care claims for Minor Consent beneficiaries.

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[2] The trial court sustained Department's objection to a statement by David McGuire (McGuire), Provider's owner and president, that when he checked with Department regarding the delayed payments, "[t]here was no mention that [Day Care] claims would not be processed or paid for Minor Consent clients."

2. *Health Services denies Provider's claims for Day Care services provided to Minor Consent beneficiaries and decides to seek reimbursement.*

Provider submitted claims to Health Services through Department for fiscal years 2006-2007 and 2007-2008. The claims included Day Care services provided to Minor Consent beneficiaries. Health Services, through the Short-Doyle system, reviewed the claims to determine whether the beneficiaries had full scope Medi-Cal, which is required for EPSDT services, which are benefits eligible for Federal Participation.

All of the disputed claims were submitted under aid codes 7M and 7P, which do not include pregnancy-related services. Thus, eligibility for Day Care services would have to be based on receipt of EPSDT services. Because neither of these aid codes indicated that the beneficiaries had full scope Medi-Cal eligibility and thus were eligible for EPSDT services, the claims were denied.

According to King, Department's Fiscal Management and Accountability Branch "inadvertently reimbursed all [Day Care] services for Minor Consent clients who were not eligible under Title 22 from the [State General Fund] because the claims appeared to be approved payable claims with [State General Fund] funding. This practice was followed throughout FY 2005-2006, FY 2006-2007, and FY 2007-2008." In 2008, Health Services "discovered the erroneous reimbursement of ineligible claims to [Provider] and two county providers. Because these [Day Care] services to Minor Consent clients were not reimbursable under Title 22, in or about July 2008, [Department] ceased reimbursing [Provider] for [Day Care s]ervices provided to Minor Consent clients. In October 2008, [Department] informed [Provider] of its intent to cease reimbursement for such services and to recoup any funds that were improperly paid to [Provider], as well as the counties."

King explained that Department "ceased payments of these ineligible claims for services provided to ineligible Minor Consent clients not because of a policy change, but rather to correct the improper reimbursement for services that did not meet statutory and contract requirements. The [Short-Doyle] system denied the claims that were not eligible for EPSDT services or related to pregnancy because those beneficiaries were not full

scope eligible and therefore [Department] receives no federal funding as a source of payment." King added that "[n]one of the claims that were denied payment . . . included a full scope Medi-Cal identification number. Moreover, any claims with a full scope Medi-Cal identification number were approved by [Health Services] and paid. All of those claims were eligible for drawing down the federal share of funding."

As to why it took so long to discover the error, King stated that each fiscal year, Provider "provides a Cost Report to [Department] which [Department] reviews and provides a Cost Report settlement to [Provider] indicating any amount that is due back to the State for that FY." According to David Neilsen, Deputy Director of Department's Program Services Division, "cost reports take typically about two years to settle." There are a number of factors affecting the amount of time it takes to settle a cost report, including the timeliness of the initial cost report, and whether there are other cost reports that need to be settled first.

Department informed Provider it would cease making payments for these services in October 2008. In 2010, Department sent written notice of its demand for repayment of sums erroneously paid to Provider for fiscal years 2006-2007 and 2007-2008.

PROCEDURAL BACKGROUND

A. *Provider's Complaint*

Provider filed this action on June 23, 2009. In its operative third amended complaint, it alleged causes of action for breach of contract, account stated, and violation of its civil rights under section 1983 of title 42 of the United States Code. In its breach of contract cause of action, it alleged that under its contract with Department, it was to provide and be paid for Day Care services to Minor Consent beneficiaries. Department breached the contract by wrongfully denying payment for those services already provided. In its account stated cause of action, Provider alleged an account stated for services rendered under the contract, which Department refused to pay.

In its civil rights cause of action, Provider alleged an equal protection violation. It claimed Department violated its "right to freedom of race and religion as an African-American Moslem" by treating Provider differently than "all other Caucasian, Non-Moslem owned [Drug Medi-Cal] providers, such as Atlantic Recovery Services . . . ."[3]

On its first two causes of action, Provider sought $7,878,682.31 in amounts unpaid under its contract, plus interest and penalties. On its third cause of action, it sought $45 million plus interest and attorneys' fees.

Department filed its answer to Provider's third amended complaint denying the allegations of the complaint and asserting numerous affirmative defenses.

B. ***Department's Motion for Summary Adjudication of Issues on Provider's Complaint***

About May 4, 2012, Department filed its motion for summary adjudication of issues, seeking adjudication of four legal issues: (1) Provider was not entitled to reimbursement for Day Care services provided to Minor Consent beneficiaries who were not eligible for EPSDT, pregnant, or post-partum; (2) a Medi-Cal beneficiary is eligible for EPSDT only if he or she is eligible for all Medi-Cal services; (3) Department's Cost Report settlement for fiscal year 2006-2007 properly denied reimbursement for Day Care services provided to Minor Consent beneficiaries "who were not approved for federal or state reimbursement because those beneficiaries were billed under the 7M and 7P aid codes"; and (4) Department's Cost Report settlement for fiscal year 2007-2008 properly denied reimbursement for Day Care services provided to Minor Consent beneficiaries "who were not approved for federal or state reimbursement because those beneficiaries were billed under the 7M and 7P aid codes."

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[3] The trial court sustained Department's objection to evidence concerning special consideration given to Atlantic Recovery Services regarding erroneously paid Day Care services claims. In this appeal, Provider does not raise any issues with respect to this cause of action.

The trial court granted Department's motion on December 18, 2012. It found "no triable issue of material fact presented as [to] Issue No. 1, which is resolved by reference to the contract. The contract, at Article V, expressly limits coverage for Day Care . . . services to those 'eligible Medi-Cal beneficiaries' who are 'pregnant or postpartum and EPSDT only beneficiaries.'"

The court additionally found "[t]here does not appear to be a triable issue of material fact as to Issue No. 2. The facts that are disputed by [Provider] are not material to Issue No. 2, as phrased."

The court further found "no triable issue of material fact as to Issues Nos. 3 and 4. Department provides evidence that it was not obligated to pay the claims because the disputed claims were submitted within the Minor Consent category, but none of the disputed claims included information that would have established full Medi-Cal eligibility (and, consequently, EPSDT-eligibility), and none of the disputed claims involved pregnant or post-partum clients. . . . Although [Provider] disputes that full Medi-Cal eligibility is required for EPSDT-eligibility, the contract itself requires that clients be 'eligible Medi-Cal beneficiaries.' (Article V.) Additionally, although [Provider] argues that EPSDT-eligible individuals are entitled to services, [Provider] provides no evidence that it billed the claims in a manner that allowed [Department] to verify EPSDT-eligibility."[4]

C. *Department's Cross-Complaint*

Department filed its cross-complaint on July 3, 2012, alleging causes of action for breach of contract and declaratory relief. In its breach of contract cause of action, Department alleged that Provider agreed to repay any amounts paid to it which exceeded its "approved and validly claimed units of service" and failed to repay amounts that Department "wrongfully paid on behalf of clients who were eligible only for Minor

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[4] On February 6, 2013, we denied Provider's petition for writ of mandate concerning this ruling.

Consent services, and not entitled to reimbursement for [Day Care s]ervices." Department sought reimbursement of $1,375,546.96 for fiscal year 2006-2007 and $1,494,327.48 for fiscal year 2007-2008.

In its declaratory relief cause of action, Department sought a declaration that Provider was "not entitled to compensation for [Day Care] services rendered to Minor Consent clients pursuant to the FY 2006-2007 and FY 2007-2008 Contracts for beneficiaries for whom [Provider] did not seek reimbursement on the basis that such clients were full-scope Medi-Cal eligible or pregnant/post-partum," and "[t]hat [Provider] is required to reimburse [Department] for payments made for such services" under the two contracts.

Provider filed an answer denying the allegations of the cross-complaint and asserting a number of affirmative defenses. These included that Department's claims for relief were barred by its failure to comply with California Code of Regulations, title 22, section 51047, subdivision (a), and equitable defenses, including estoppel.

D. ***Department's Motion for Summary Judgment on Its Cross-complaint***

On January 25, 2013, Department moved for summary judgment or, in the alternative, summary adjudication on its cross-complaint. Based on the evidence submitted and judicial notice of its ruling on Department's summary adjudication motion, the trial court granted the motion.

The trial court found that Department established that Provider owed it $2,823,648.04 reimbursement for Day Care services provided to Minor Consent beneficiaries "who were not approved for federal or state reimbursement because those beneficiaries were billed under the 7M and 7P aid codes." The court found that Provider proffered no admissible evidence to contradict the facts presented in the motion. The court found that Provider's "suggestion that [Department] should be equitably estopped from seeking reimbursement is, effectively, a defensive quantum meruit argument. The quantum meruit theory of recovery is inapplicable to government entities."

The trial court also rejected Provider's arguments that Department did not give it 60 days to submit additional information or allow 60 days before stopping payments. It explained the arguments did not apply because "the claimed breach is [Provider]'s failure to reimburse [Department] for payments that were actually made."

E. *Judgment*

The parties then entered into a stipulation for judgment against Provider on its third amended complaint and in favor of Department on its cross-complaint. Because "a trial on the remaining breach of contract claim in [Provider]'s complaint would be futile and a waste of limited judicial resources," the parties stipulated for entry of judgment "in order to minimize additional proceedings in the trial court and to put the case in a position for immediate appeal to the Court of Appeal regarding the adverse determination of critical issues on summary adjudication . . . ."

The trial court entered judgment in accordance with the stipulation on July 29, 2013. It awarded Department $2,823,648.04 plus interest on its cross-complaint. Provider filed its notice of appeal on September 4, 2013.

DISCUSSION

A. *Standard of Review*

On appeal, Provider challenges both the summary adjudication of issues and the summary judgment in favor of Department. Under Code of Civil Procedure section 437c, subdivision (f)(1), "A party may move for summary adjudication as to one or more causes of action within an action, one or more affirmative defenses, one or more claims for damages, or one or more issues of duty, if that party contends that the cause of action has no merit or that there is no affirmative defense thereto, or that there is no merit to an affirmative defense as to any cause of action, or both, or that there is no merit to a claim for damages, . . . or that one or more defendants either owed or did not owe a duty to the plaintiff or plaintiffs. A motion for summary adjudication shall be granted only if it

completely disposes of a cause of action, an affirmative defense, a claim for damages, or an issue of duty."

Here, by stipulation, the parties proceeded under Code of Civil Procedure former section 437c, subdivision (s),[5] which provided: "(1) Notwithstanding subdivision (f), a party may move for summary adjudication of a legal issue or a claim for damages other than punitive damages that does not completely dispose of a cause of action, an affirmative defense, or an issue of duty. [¶] (2) This motion may be brought only upon the stipulation of the parties whose claims or defenses are put at issue by the motion and a prior determination and order by the court that the motion will further the interest of judicial economy, by reducing the time to be consumed in trial, or significantly increase the ability of the parties to resolve the case by settlement."

Under subdivision (c) of Code of Civil Procedure section 437c, a "motion for summary judgment shall be granted if all the papers submitted show that there is no triable issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. In determining whether the papers show that there is no triable issue as to any material fact the court shall consider all of the evidence set forth in the papers, except that to which objections have been made and sustained by the court, and all inferences reasonably deducible from the evidence, except summary judgment may not be granted by the court based on inferences reasonably deducible from the evidence, if contradicted by other inferences or evidence, which raise a triable issue as to any material fact." (See also *Biancalana v. T.D. Service Co.* (2013) 56 Cal.4th 807, 813; *Aguilar v. Atlantic Richfield Co.* (2001) 25 Cal.4th 826, 843.)

"For purposes of motions for summary judgment and summary adjudication: [¶] . . . [¶] . . . A defendant or cross-defendant has met his or her burden of showing that a cause of action has no merit if that party has shown that one or more elements of the cause of action, even if not separately pleaded, cannot be established, or that there is a

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5 Subdivision (s) was repealed by its own terms on January 1, 2015.

complete defense to that cause of action. Once the defendant or cross-defendant has met that burden, the burden shifts to the plaintiff or cross-complainant to show that a triable issue of one or more material facts exists as to that cause of action or a defense thereto. The plaintiff or cross-complainant may not rely upon the mere allegations or denials of its pleadings to show that a triable issue of material fact exists but, instead, shall set forth the specific facts showing that a triable issue of material fact exists as to that cause of action or a defense thereto." (Code Civ. Proc., § 437c, subd. (p)(2).)

The same standard of review applies to both an order granting summary adjudication and an order granting summary judgment. (*City of Glendale v. Marcus Cable Associates, LLC* (2014) 231 Cal.App.4th 1359, 1376; *Davis v. Kiewit Pacific Co.* (2013) 220 Cal.App.4th 358, 363.) "'We "independently assess the correctness of the trial court's ruling by applying the same legal standard as the trial court in determining whether any triable issues of material fact exist, and whether the defendant is entitled to judgment as a matter of law." [Citation.]'" (*City of Glendale*, *supra*, at p. 1376.) In reviewing the trial court's ruling, "'[w]e are not bound by the trial court's reasons for granting summary judgment because we review the trial court's ruling, and not its rationale.' [Citation.]" (*Dameron Hospital Assn. v. AAA Northern California, Nevada & Utah Ins. Exchange* (2014) 229 Cal.App.4th 549, 558.)

"'In reviewing the evidence, we strictly construe the moving party's evidence and liberally construe the opposing party's and accept as undisputed only those portions of the moving party's evidence that are uncontradicted.' [Citation.] 'Only when the inferences are indisputable may the court decide the issues as a matter of law. If the evidence is in conflict, the factual issues must be resolved by trial. "Any doubts about the propriety of summary judgment . . . are generally resolved *against* granting the motion, because that allows the future development of the case and avoids errors."' [Citation.]" (*Scalf v. D. B. Log Homes, Inc.* (2005) 128 Cal.App.4th 1510, 1519; accord, *Ahn v. Kumho Tire U.S.A., Inc.* (2014) 223 Cal.App.4th 133, 137; see also *Salas v. Sierra Chemical Co.* (2014) 59 Cal.4th 407, 415.)

B. ***Whether the Trial Court Erred in Granting Department's Summary Adjudication Motion***

Provider contends that the trial court erred in granting the motion for summary adjudication as to Department's four issues, because triable issues of material fact exist as to each of these issues. It claims that "[t]he trial court was only able to grant summary adjudication on all four issues by focusing solely on one clause of the parties' two contracts, while ignoring the remainder of the contracts, and by ignoring the broad mandate of federal law to provide EPSDT services to minors."

Additionally, Provider argues that the Contract was ambiguous, and when interpreting the Contract, the trial court erroneously "refused to consider evidence submitted by [Provider] about the meaning and performance of the contracts and granted [Department]'s objections that the evidence was 'irrelevant' parol evidence. When this evidence is considered, or, when at a minimum the contracts are considered as a whole . . . , as they should have been, there is a triable issue of material fact on each of the four Issues presented."

On summary adjudication/judgment, we "independently review contractual agreements, including the question of whether the language used in a contract is ambiguous." (*Dameron Hospital Assn. v. AAA Northern California, Nevada & Utah Ins. Exchange*, *supra*, 229 Cal.App.4th at p. 558.) "To the extent that resolution of the case turns on an interpretation of statutory law, we also make an independent interpretation of the statutes involved. [Citations.]" (*Committee to Save the Beverly Highlands Homes Assn. v. Beverly Highlands Homes Assn.* (2001) 92 Cal.App.4th 1247, 1261.)

1. *Is there a triable issue of material fact as to whether the law and the Contract expressly provide for reimbursement from the State General Fund for Day Care services provided to Minor Consent beneficiaries?*

The trial court found as to Issue No. 1 that Provider "is not entitled to reimbursement for Day Care . . . [s]ervices . . . as defined by California Code of Regulations, title 22, section 51341.1, subdivision (b)(6), for those beneficiaries for

whom [Provider] sought reimbursement under Minor Consent beneficiary eligibility pursuant to California Code of Regulations, title 22, section 50063.5, and who were not federally eligible under the EPSDT program, or who were not pregnant or post-partum." It found as to Issue No. 2 that "[a] Medi-Cal beneficiary is federally eligible under the EPSDT program if he or she is EPSDT eligible pursuant to California Code of Regulations, title 22, or if he or she is fully eligible under the Medi-Cal program for all services."

Provider contends the trial court erroneously granted summary adjudication of these issues. To resolve this contention, we first examine the Contract language.

a. *Applicable Contract Provisions*

i. *Contract Language*

Article V, Provision of Services, in the terms and conditions of the Contract states that Provider "shall provide covered substance abuse treatment services for eligible Medi-Cal beneficiaries in need of such services." Provider argues that "[i]n relying only on this one clause of Article V, the trial court, however, completely ignored that both of the Contracts were for the ***express*** purpose of providing millions of dollars in reimbursement to [Provider] for Day Care . . . services to Minor Consent eligible clients. It must be acknowledged that [Provider] was awarded contracts expressly to provide [Day Care s]ervices to Minor Consent beneficiaries."

It is not only this one clause of the Contract, however, that is relevant to the circumstances under which Day Care services are reimbursable. Article IV of both the 2004-2005 contract and 2007-2008 contract defines "Covered Services" as Drug Medi-Cal services "authorized by Title XIX of the Social Security Act and specified in Title 22, [California Code of Regulations], [s]ection 51341.1; [Health and Safety Code] [s]ection 11758.46; the [Welfare & Institutions Code]; and California's Medicaid State Plan. Covered services are Naltrexone treatment, outpatient drug free treatment, narcotic treatment, [D]ay [C]are rehabilitative (for pregnant and perinatal beneficiaries and those receiving EPSDT services) and perinatal residential substance abuse treatment."

(Emphasis added.) Thus, within the definition of covered services, Day Care services are limited to services for pregnant and perinatal beneficiaries and those receiving EPSDT services.

Also within the definitions section, the Contract is clear that the EPSDT program is only for full-scope Medi-Cal beneficiaries. Article IV states that EPSDT "means the federally mandated Medicaid benefit for full-scope Medi-Cal beneficiaries under 21 years of age that provides any Medicaid service necessary to correct or ameliorate a defect, or mental illness, or other condition . . . ." Article IV also defines "Minor Consent Drug Medi-Cal . . . Services" as "substance abuse treatment services and other services defined in Title 22, [California Code of Regulations], [s]ection 50063.5, that may be provided to a person aged 12 through 20, without parental consent. Reimbursement for minor consent services is by 100 percent [State General Fund]."

Article IV specifies that "'Unit of Service' for outpatient drug free, [D]ay [C]are rehabilitative, perinatal residential, and Naltrexone treatment services means a face-to-face contact on a calendar day." The accompanying chart shows the maximum allowance per unit of service. For Day Care services, the chart shows the maximum allowance for both perinatal and non-perinatal units of service. In the chart, the maximum charge per non-perinatal unit of service is indicated as "for EPSDT only." Thus the contract terms are consistent in demonstrating that Provider could only offer Day Care services for specified populations: pregnant and post-partum minors; and those fully eligible to receive EPSDT services.

Provider argues the proposed budget forms, incorporated by reference in the Contract, which list the units of service, unit of service rates, and proposed budgets for services it was authorized to provide show it was authorized to provide Day Care services to Minor Consent clients. It is true that these budget forms clearly state that Provider was providing Minor Consent services, the bulk of which were for Day Care services. Nonetheless, nothing in these forms indicate that Day Care services can be provided to minors other than those identified in the Contract. All the pertinent terms in the budget forms are defined in the Contract terms and conditions, which make it clear that Day Care

services for non-pregnant, non-postpartum clients are authorized for EPSDT clients only. EPSDT clients must be full-scope Medi-Cal beneficiaries.

Similarly, the budget forms indicate that the state's share of funding for Day Care services would be 100 percent. Provider argues that "[a]s a result of these provisions, [Department] was fully aware and intended that [Provider] would provide Day Care . . . services to Minor Consent beneficiaries and seek reimbursement." However, the proposed budget forms do not establish that Department agreed to pay for Day Care services for Minor Consent beneficiaries who were not pregnant, post-partum, or EPSDT clients. The proposed budget forms just establish that the Contract included Day Care services for Minor Consent beneficiaries.[6]

ii. *Parol Evidence*

As previously mentioned, the trial court sustained Department's objections to evidence Provider sought to admit concerning the parties' understanding of the scope of the Contract. Provider claims this was error.

"When the meaning of the words used in a contract is disputed, the trial court engages in a three-step process. First, it provisionally receives any proffered extrinsic evidence that is relevant to prove a meaning to which the language of the instrument is reasonably susceptible. [Citations.] If, in light of the extrinsic evidence, the language is reasonably susceptible to the interpretation urged, the extrinsic evidence is then admitted to aid the court in its role in interpreting the contract. [Citations.] When there is no material conflict in the extrinsic evidence, the trial court interprets the contract as a matter of law. [Citations.] This is true even when conflicting inferences may be drawn from the undisputed extrinsic evidence [citations] or that extrinsic evidence renders the contract terms susceptible to more than one reasonable interpretation. [Citations.] If,

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[6] Nothing prevented Provider from providing Day Care services under Minor Consent to pregnant or post-partum beneficiaries, and being reimbursed by Department from State General Funds.

however, there is a conflict in the extrinsic evidence, the factual conflict is to be resolved by the jury. [Citations.]" (*Wolf v. Walt Disney Pictures & Television* (2008) 162 Cal.App.4th 1107, 1126-1127, fn. omitted; accord, *Pacific Gas & Elec. Co. v. G. W. Thomas Drayage & Rigging Co.* (1968) 69 Cal.2d 33, 38-40.) Thus, the trial court should have provisionally received the proffered parol evidence to determine whether it was relevant to prove a meaning to which the language of the Contract was reasonably susceptible.

We describe below the evidence excluded regarding the meaning of the contract,[7] and consider whether its provisional consideration would have changed the result with respect to the motion for summary adjudication.

The trial court excluded portions of the McGuire declaration. The excluded evidence includes McGuire's statement that at the time he signed the Contract, he was informed by Department that he could provide Day Care services to Minor Consent clients and that those services would be reimbursed; that he relied on that information in providing services; that Department employees visited the school sites where services were going to be provided and confirmed that Provider would be providing Day Care services to Minor Consent beneficiaries; that he was trained in how to bill for Day Care services to Minor Consent beneficiaries and that billing instructions did not mention that special codes were needed to identify EPSDT eligible clients; that during audits performed between 2004 and 2008 he was not informed that he could not bill for Day Care services to Minor Consent beneficiaries; that during visits to the school sites Los Angeles County Social Services representatives did not advise minors in the program that they needed a full scope medical card to receive Day Care services; that Department was aware of the types of services being provided and instructed that payment be made for

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[7] We do not consider other evidence that was properly excluded as not relevant to contract interpretation, and which lacked foundation, such as Department's purported resolution of an allegedly similar dispute with another provider, Atlantic Recovery Systems.

Day Care services to Minor Consent beneficiaries; and that in May 2008 in response to Provider's e-mail, the Department made no mention that Minor Consent beneficiaries could not receive Day Care services.

The trial court also excluded portions of the declaration of Edna Miller, Provider's program director. The excluded evidence includes statements which largely mirror the McGuire statements above described. The trial court excluded portions of the declaration of Gwendolyn Nicholas, who worked for the Department during the Contract period as an analyst in the Drug Medi-Cal Compliance Branch. The excluded evidence includes her statement that she found only minor deficiencies in her review of Provider's billings during two post-service, post-payment reviews; that there was nothing in the specific California Code of Regulations, title 22, sections 51341.1, 51490.1, and 51516.1 that she used in her review that would have indicated that Day Care services cannot be rendered to Minor Consent clients; that she was never informed prior to 2009 that Day Care services delivered to Minor Consent clients would not be reimbursed unless a minor used a full scope Medi-Cal card; and that she believed those services were reimbursable without such a card.

Provider argues this evidence supports its interpretation of the contract; namely, that Department would reimburse for Day Care services for Minor Consent beneficiaries, irrespective of whether those beneficiaries were pregnant, post-partum, or EPSDT-eligible. Provider's president and a former employee of Department presented their understanding that Day Care services could be provided to Minor Consent beneficiaries who were not fully Medi-Cal eligible. We conclude the Contract is reasonably susceptible of that meaning and the extrinsic evidence should have been admitted to aid the trial court in interpreting the contract. However, as there is no material dispute in the extrinsic evidence, we may interpret the contract as a matter of law in light of this evidence. (*Jade Fashion & Co., Inc. v. Harkham Industries, Inc.* (2014) 229 Cal.App.4th 635, 652; *Wolf v. Superior Court* (2004) 114 Cal.App.4th 1343, 1351.)

The Contract language expressly limits reimbursement for Day Care services to beneficiaries falling within the three categories. Moreover, nothing in Provider's

evidence suggests that the Department specifically told Provider that, despite the Contract's limitation, it would reimburse for Day Care services provided to Minor Consent clients who did not meet the specified criteria. The inference we draw, consistent with Department's position, is that the Department made a mistake when processing claims for reimbursement under the Contract, not that the parties intended the Contract to mean something different. This conclusion is also consistent with federal and state law related to the Medicaid and Medi-Cal programs as discussed below.

b. *Applicable Statutory Provisions*

i. *Federal Medicaid Program*

The federal "Medicaid program, established by title XIX of the Social Security Act, 42 United States Code sections 1396-1396g, is a medical assistance program jointly funded by the federal and state governments. The California program is known as Medi-Cal. (Welf & Inst. Code, § 14000 et seq.) Under the Medicaid program, states receive [Federal Participation] for services specified under federal law. The states may provide services that are not provided for under federal law, but they do so entirely at their own expense." (*Crespin v. Kizer* (1990) 226 Cal.App.3d 498, 504; accord, *Dominguez v. Superior Court* (1990) 226 Cal.App.3d 524, 528.)

Under Medicaid, Federal Participation is available for the full range of Medicaid services—full-scope services or benefits—to citizens, legal permanent residents, and aliens with status as permanent residents. (*Crespin v. Kizer*, *supra*, 226 Cal.App.3d at p. 504.) Under Medi-Cal, California similarly limits full-scope benefits to certain aliens and provides limited benefits to those who do not meet the requirements for full-scope benefits. (Welf. & Inst. Code, § 14007.5, subds. (b), (d); *Dominguez v. Superior Court*, *supra*, 226 Cal.App.3d at p. 529.) In order to be eligible for full-scope Medi-Cal benefits, a beneficiary must provide a social security number and proof of immigration status. (Welf. & Inst. Code, § 14007.5, subds. (e), (f)(1).) Otherwise, a beneficiary is eligible only for limited benefits. (*Id*., subd. (g)(1).)

Federal Medicaid law requires that states provide EPSDT services to Medicaid-eligible children under 21. (*Rosie D. ex rel. John D. v. Swift* (1st Cir. 2002) 310 F.3d 230, 232; *Rosie D. v. Romney* (D.Mass 2006) 410 F.Supp.2d 18, 25; *Emily Q. v. Bonta* (C.D.Cal. 2001) 208 F.Supp.2d 1078, 1089; see 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(B).) The requisite EPSDT services include "preventive health care (e.g., vision, hearing, and dental services)," plus "'such other necessary health care, diagnostic services, treatment, and other measures described [as medical assistance] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan.' [42 U.S.C.] § 1396d(r)(5)." (*Rosie D. ex rel. John D.*, *supra*, at p. 232.)

Provider takes the position that federal law "mandates that states provide EPSDT services to children and youth under 21 years of age" for medically necessary services included within the EPSDT program, whether or not the children are full-scope Medi-Cal beneficiaries. Provider focuses on the medically necessary aspect of the EPSDT program. All the cases Provider cites in support of its position, however, make it clear that EPSDT services must be provided to *Medicaid-eligible* individuals and families. (See, e.g., *Collins v. Hamilton* (7th Cir. 2003) 349 F.3d 371, 374 [Medicaid Act "allow[s] states to provide 'medical assistance' to eligible individuals and families with insufficient income or resources to pay for necessary medical services"]; *Rosie D. ex rel. John D. v. Swift*, *supra*, 310 F.3d at p. 232 [Congress augmented the Medicaid "program's coverage to provide [EPSDT] services to Medicaid-eligible children"]; *Emily Q. v. Bonta*, *supra*, 208 F.Supp.2d at p. 1089 ["[u]nder EPSDT, [the state] is obligated to cover a broad range of mental health services for Medi-Cal eligible children under the age of 21"].)[8]

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[8] The trial court sustained Department's objections to a doctor's declaration regarding the medical necessity of Day Care services provided to Provider's clients on the ground the evidence was irrelevant. The court sustained Department's objections to the doctor's statements regarding the clients' EPSDT eligibility as irrelevant and improper lay opinion. These rulings were correct. The relevant issue here is eligibility for EPSDT services, not whether the services were medically necessary. (Evid. Code, §§ 210, 350.) The interpretation of statutes is a judicial function (*McClung v.*

For example, in *John B. v. Menke* (M.D.Tenn. 2001) 176 F.Supp.2d 786, one of the cases Provider cites, the court stated that "the State is bound by federal law to provide 'medically necessary' EPSDT services that fall within the scope of services listed at 42 [United States Code section] 1396d(e) to all state residents under the age of 21. The State has discretion with respect to the provision of these services, so long as the plan 'complies satisfactorily' with federal law. [Citation.]" (*Id*. at p. 800.) The court later stated, however, that "[a]lthough States may take advantage of Medicaid waivers under Section 1915 of the Social Security Act, the 'waiver may not be used to deny, delay, or limit access to medically necessary services that are required to be available to all *Medicaid-eligible* children under federal EPSDT rules.' EPSDT services are not optional, and may not be limited, even pursuant to a Medicaid waiver."[9] (*Ibid*., italics added, fns. omitted.)

From the foregoing, it is clear that, under the federal Medicaid law, if Day Care services are medically necessary within the meaning of the EPSDT program, federal law requires that the state provide them to children under the age of 21 who are Medicaid-eligible. That is, the services must be provided to children under 21 with full-scope Medi-Cal coverage for whom Federal Participation is available.

ii. *State Law as to Eligibility for Day Care Services*

Regulations concerning the operation of Medi-Cal are contained in the California Code of Regulations, title 22, section 50000 et seq. Section 50063.5(a)(2) of the regulations defines Minor Consent services as "services related to" various health issues, including "[d]rug or alcohol abuse for children 12 years of age or older." Section

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Employment Development Dept. (2004) 34 Cal.4th 467, 470), and the evidence offered would have been improper expert opinion.

9 The state had received a waiver of certain state plan requirements for experimental, pilot, or demonstration projects available under 42 United States Code section 1315. (*John B. v. Menke*, *supra*, 176 F.Supp.2d at p. 788.)

51341.1 provides: "(a) Substance use disorder services, as defined in this section, provided to a Medi-Cal beneficiary, shall be covered by the Medi-Cal program when determined medically necessary in accordance with Section 51303. Services shall be prescribed by a physician, and are subject to utilization controls, as set forth in Section 51159.

"(b) For the purposes of this Section, the following definitions and requirements shall apply: [¶] . . . [¶] (8) 'Day Care habilitative services' means outpatient counseling and rehabilitation services provided at least three (3) hours per day, three (3) days per week to persons with substance use disorder diagnoses, who are pregnant or postpartum, and/or to Early and Periodic Screening Diagnosis, and Treatment (EPSDT)-eligible beneficiaries, as otherwise authorized in this Chapter."

Welfare and Institutions Code section 14132.905, subdivision (a), which California Code of Regulations, title 22, section 51341.1 implements, provides that for purposes of Medi-Cal, "Day Care habilitative services, pursuant to subdivision (c) of [Welfare and Institutions Code s]ection 14021, shall be provided only to alcohol- and drug-exposed pregnant women and women in the postpartum period, or as required by federal law." Thus, California Code of Regulations, title 22, section 51341.1 equates EPSDT eligibility with those for whom Day Care services are required under federal law, i.e., full-scope Medi-Cal beneficiaries.

With respect to Minor Consent beneficiaries, section 50147.1 of title 22 of the California Code of Regulations provides in pertinent part: "(a) A child may apply for Medi-Cal without parental contact in order to receive minor consent services. [¶] (b) A child applying on the basis of a need for minor consent services other than mental health care shall submit to the county welfare department a completed and signed form Request for Eligibility for Limited Services indicating the need for services related to one or more of these needs." These subdivisions make it clear that under the Minor Consent program,

beneficiaries do not need to have full-scope Medi-Cal eligibility, but they are eligible only for certain services.[10]

Provider nonetheless argues that "nothing in state law prohibits Minor Consent beneficiaries from receiving [Day Care] or EPSDT services, despite [Department]'s arguments that only 'full-scope Medi-Cal beneficiaries' can receive EPSDT services." Provider points to section 50063.5 of title 22 of the California Code of Regulations, which provides that Minor Consent services include services related to "[d]rug or alcohol abuse for children 12 years of age or older," and argues that "[t]he alcohol and substance abuse treatment services provided by [Provider] to its Minor Consent clients fit squarely within" this definition.

State law is clear, however, that Minor Consent services are limited, and Day Care services in particular are available only to children under 21 who are pregnant, post-partum, or who have full-scope Medi-Cal eligibility under the EPSDT program. State law does not provide for the provision of Day Care services to Minor Consent beneficiaries who are not otherwise eligible for the services, and Provider cites no statute or regulation to the contrary.

Provider also argues that it "submitted evidence that in California Child Health and Disability Prevention Program . . . operates a[n] EPSDT screening services [program] called Gateway for children who are not 'full scope Medi-Cal beneficiaries' and do not have other means to access preventive health care. . . . This evidenced that under California law, a child could be receiving EPSDT services and not be a 'full scope Medi-Cal beneficiary.'"

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[10] Subdivision (d) of section 50147.1, of title 22 of the California Code of Regulations, dealing with the county welfare department's processing of the child's application, further makes it clear that eligibility for Minor Consent services is different from Medi-Cal eligibility. Subdivision (d)(3)(C) provides that if the child is applying for Medi-Cal based on the need for mental health care, "the county department shall" "[d]eny the application if the child is currently eligible for Medi-Cal and enrolled in a PHP [prepaid health plan] or PCCM [primary care case management] plan and refer the child to the PHP or PCCM plan for care." (See *id.*, §§ 50071.8, 53810, subd. (ee).)

The trial court sustained Department's objection to this evidence on the ground of irrelevancy, in part because none of Provider's claims for reimbursement were submitted through the Child Health and Disability Prevention program and Provider was not a California Child Health and Disability program provider. Provider makes no argument that the trial court's ruling was incorrect or that the provision of EPSDT services through the Gateway program was in any way involved in the contract between Provider and Department.

iii. *Department's "Embellishment" of the Regulations*

Provider also complains that "[t]he trial court . . . failed to address that Department embellished and enforced a term of a regulation by concluding what the meaning of EPSDT is, including adding the language of 'full scope Medi-Cal' without complying with the rulemaking procedures of the Administrative Procedure Act" (Gov. Code, § 11340 et seq.). This provides that "[n]o state agency shall issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in Section 11342.600, unless the guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule has been adopted as a regulation and filed with the Secretary of State pursuant to this chapter." (*Id.*, § 11340.5, subd. (a).)

In Provider's view, "a triable issue of material fact existed as to whether [Department] could embellish regulations so that Minor Consent beneficiaries cannot be eligible for EPSDT because they are not 'full-scope Medi-Cal.'" To the contrary, the law is clear that the EPSDT program is available to Medicaid/full-scope Medi-Cal eligible children only. Department did not "embellish" any regulations to reach this conclusion.

2. *Is there a triable issue of material fact as to whether Department's denial of reimbursement was proper?*

The trial court found as to Issue Nos. 3 and 4 that Department's cost reports for fiscal years 2006-2007 and 2007-2008 "properly denied reimbursement to [Provider] in

accordance with the parties' contract[s] . . . for Day Care . . . [s]ervices provided to Minor Consent eligible clients who were not approved for federal or state reimbursement because those beneficiaries were billed under the 7M and 7P aid codes."

Provider contends the trial court's findings were in error, because "[t]he disputed facts are that [Department] never provided [Provider] with any means with which to communicate during the billing process whether its Minor Consent clients were EPSDT eligible. It's not that [Provider] provided the wrong information or in the wrong format. [Department] never asked [Provider] to supply the information it now claims it needs to determine EPSDT eligibility. [Department] simply decided to deny the claims after paying them for four years. Thus, when all of the evidence from [Department] and [Provider] is considered, there were triable issues about whether [Department] 'properly denied' reimbursement."

In support of its contention, Provider cites Department's 2001 revision of its instructions for completing form 1584. The revised instructions stated: "Minor Consent and EPSDT claims no longer need to be submitted on a separate claim. Minor Consent has aid codes to identify the type of service for which the client is eligible. [Department] can use the aid code to query the data for statistical information. [¶] EPSDT claims no longer need to be submitted on a separate claim. [Department] can use the client age and some filters to query data for statistical information."

Provider claims it "followed this directive and submitted its claims accordingly. And for nearly four years, it was reimbursed by [Department] for the services provided to Minor Consent beneficiaries."

Provider does not explain specifically how the revised instructions[11] or the reimbursement of claims for four years create a triable issue of fact as to whether Department properly denied reimbursement for claims submitted under the 7M and 7P aid codes. Neither does it cite any authority to support its position. Rather, Provider

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11 We note that the amendment to the instructions occurred years before the Contract between Provider and Department at issue here.

appears to be arguing there was a triable issue of fact as to its equitable defenses. We discuss this issue below.

Provider also claims that "[w]hen [Department] suddenly stopped reimbursing, [Department]'s excuse that it had mistakenly been paying [Provider] for [Day Care] services provided to Minor Consent clients was not made known to [Provider] for over [five] months after the decision had been made to stop any payments to other providers of these services in June 2008." Provider argues this violated Article VI of the contract, which provides that "[i]f . . . Department, [Health Services], or DHHS disallows or denies payments made to the Contractor for any claim submitted by the Contractor, Contractor shall repay the State all federal Medicaid funds and [State General Funds] for any and all claims so disallowed or denied. . . . Before such denial, recoupment, or disallowances are made, the State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional Information before the proposed action is taken, as required in Title 22, [California Code of Regulations], [s]ection 51047[, subdivision] (a)."

McGuire submitted a declaration in which he states, "Had [Provider] been notified that full scope Medi-Cal cards were necessary to be reimbursed for [Day Care] services within 60 days of denying a payment, [Provider] could have advised its clients and Social Services of the same and [Provider] could have sought to seek the clients[']' full scope Medi-Cal card[s] . . . ."

Provider contends this alleged failure to provide a cure period created a triable issue of fact with respect to Issue Nos. 3 and 4 of the summary adjudication—did Department's cost report settlement for Fiscal Years 2006-2007 and 2007-2008 "properly" deny reimbursement for Day Care services to Minor Consent clients who were not approved for federal or state reimbursement. Provider did not argue that Department had violated Article VI of the Contract in opposition to the motion for summary adjudication on the complaint. Rather, in its opposition Provider argued Department's actions violated California Code of Regulations, title 22, section 51047. That regulation

relates to recovery of overpayments, however, and not to denial of reimbursement.[12] As such, this regulation is irrelevant to the motion for summary adjudication of issues under the complaint, which sought to recover moneys from Department that Provider claims were due under the Contract. We do not consider Provider's new argument that summary adjudication of Issue Nos. 3 and 4 was improper based on a new legal theory not raised in opposition to the motion below. (See *Schmidlin v. City of Palo Alto* (2007) 157 Cal.App.4th 728, 790; *North Coast Business Park v. Nielsen Construction Co.* (1993) 17 Cal.App.4th 22, 28-29.)

In sum, the trial court properly granted summary adjudication of issues on Provider's complaint. Under the law and the provisions of the Contract, Provider was not entitled to reimbursement for Day Care services provided to Minor Consent beneficiaries who were not EPSDT-eligible, pregnant, or post-partum.

C. *Whether the Trial Court Erred in Granting Department's Summary Judgment Motion*

1. *Whether the Summary Adjudication of Issues Was Dispositive as to Department's Cross-complaint*

Provider contends the summary adjudication of issues on its complaint was not dispositive as to Department's cross-complaint, because Department failed to meet its burden of proving that the Minor Consent beneficiaries for whom Provider rendered Day Care services were not EPSDT-eligible. Provider asserts there is a triable issue of fact on

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[12] Title 22 of the California Code of Regulations, section 51047 provides, in pertinent part, "When it is established upon audit that an overpayment has been made to a provider, the Department shall begin liquidation of any overpayment to a provider 60 days after issuance of the first Statement of Accountability or demand for repayment. The demand for repayment or Statement of Accountability shall be issued no later than 60 days after the issuance of the audit or examination report establishing such overpayment."

the issue based on McGuire's statement: "I am informed and believe that 95% or more of the children that [Provider] provided services to had full scope Medi-Cal."

The trial court sustained Department's objection to McGuire's statement based on a lack of personal knowledge. Moreover, it is undisputed that none of Provider's claims for reimbursement for Day Care services to Minor Consent beneficiaries included an aid code indicating eligibility to receive EPSDT services. Accordingly, the prior summary adjudication established that Provider was not entitled to reimbursement for Minor Consent beneficiaries ineligible for Day Care services.

Provider also argues summary judgment was improperly granted as there was a triable issue of fact whether Department violated either Article VI of the Contract or California Code of Regulations, title 22, section 51047, subdivision (a), by failing to inform Provider of its intent to recoup overpayments 60 days before taking action. Provider and Department agree that Provider was informed that Department would no longer pay for Day Care services for ineligible Minor Consent beneficiaries in October 2008. Department also submitted evidence that in April 2010, after completion of the review of the Cost Reports for fiscal years 2006-2007 and 2007-2008, it provided written notice to Provider it was seeking repayment of moneys erroneously paid to Provider during these time periods.

The letters also informed Provider of the process for appealing. According to the complaint in this action, well before the 2010 letter, Provider initiated an appeals process by submitting a complaint in writing to the Department in November 2008, and was engaged in appeal related activities through March 2009. Provider filed its complaint on June 23, 2009, and Department did not file its cross-complaint seeking reimbursement of funds until July 3, 2012. Provider does not claim it was denied the opportunity to submit additional information after it was notified Department would seek reimbursement for wrongly-paid claims. Provider has not shown how any violation of the 60-day period outlined in Article VI and title 22 of the California Code of Regulations, section 51047, subdivision (a), would have been material to the summary judgment of the cross-complaint.

2. *Whether Triable Issues of Material Fact Exist as to Provider's Affirmative Defenses to Department's Cross-complaint*

a. *Evidentiary Rulings*

Provider first contends the trial court "erroneously adopted its prior ruling[s] on evidentiary objections to bar evidence that raised triable issues of material fact on the Cross-complaint." Provider asserts that evidence inadmissible on the issue of contract interpretation may have been admissible on the issue of Provider's affirmative defenses. Provider fails to address any specifics, however. Where, for example, the objection was lack of personal knowledge, as with McGuire's statement regarding full-scope Medi-Cal eligibility of Provider's clients, the evidence would be inadmissible as to both issues.

A "party asserting trial court error may not . . . rest on the bare assertion of error but must present argument and legal authority on each point raised." (*Boyle v. CertainTeed Corp.* (2006) 137 Cal.App.4th 645, 649; see also Cal. Rules of Court, rule 8.204(a)(1)(C).) A conclusory argument devoid of citation to legal authority is insufficient and we may disregard it. (*Rojas v. Platinum Auto Group, Inc.* (2013) 212 Cal.App.4th 997, 1000, fn. 3; *Dabney v. Dabney* (2002) 104 Cal.App.4th 379, 384.)

Nonetheless, much of Provider's evidence discussed above with respect to the motion for summary judgment on the complaint would have been admissible on the issue of equitable estoppel. We therefore consider the effect of its erroneous exclusion on the order granting summary judgment on the cross-complaint and the subsequent judgment.

b. *Equitable Estoppel*

Provider contends the trial court erred in equating its affirmative defenses with "a defensive quantum meruit argument" and then finding "[t]he quantum meruit theory of recovery is inapplicable to government entities." As Provider claims, it did specifically plead estoppel as an affirmative defense, and estoppel may be applied against the government in certain circumstances. The question is whether such circumstances are present here.

The elements of equitable estoppel include: "'(1) the party to be estopped must be apprised of the facts; (2) he must intend that his conduct shall be acted upon, or must so act that the party asserting the estoppel had a right to believe it was so intended; (3) the other party must be ignorant of the true state of facts; and (4) he must rely upon the conduct to his injury.'" (*City of Long Beach v. Mansell* (1970) 3 Cal.3d 462, 489.)

"It is settled that '[the] doctrine of equitable estoppel may be applied against the government where justice and right require it. [Citation.]' [Citation.] [Citations.] Correlative to this general rule, however, is the well-established proposition that an estoppel will not be applied against the government if to do so would effectively nullify 'a strong rule of policy, adopted for the benefit of the public . . . .' [Citation.] The tension between these twin principles makes up the doctrinal context in which concrete cases are decided." (*City of Long Beach v. Mansell*, *supra*, 3 Cal.3d at p. 493.)

We apply a balancing test in determining whether to apply estoppel: "'The government may be bound by an equitable estoppel in the same manner as a private party when the elements requisite to such an estoppel against a private party are present and, in the considered view of a court of equity, the injustice which would result from a failure to uphold an estoppel is of sufficient dimension to justify any effect upon public interest or policy which would result from the raising of an estoppel.'" (*Lentz v. McMahon* (1989) 49 Cal.3d 393, 400, quoting from *City of Long Beach v. Mansell*, *supra*, 3 Cal.3d at pp. 496-497.) The weighing of policy concerns is a question of law, to be decided by the court. (*City of Oakland v. Oakland Police & Fire Retirement System* (2014) 224 Cal.App.4th 210, 240.) The weight of precedent demonstrates that the government "will be estopped only in an 'exceptional case.'" (*West Washington Properties, LLC v. Department of Transportation* (2012) 210 Cal.App.4th 1136, 1146.)

The leading case on equitable estoppel against a governmental entity is *City of Long Beach v. Mansell*, *supra*, 3 Cal.3d 462. That case involved a question of whether certain lands were properly held by private parties, or were tidelands subject to the superior title of the state or city. In determining that estoppel applied, the court considered that the city had engaged in extensive activities for more than 40 years leading

thousands of homeowners to believe the land was private property, including "granting building permits, approving subdivision maps, constructing and maintaining streets and city services, collecting taxes." (*Id*. at p. 487.) The court found the facts made it an exceptional case where estoppel would apply, because of the "rare combination of government conduct and extensive reliance" which would create "an extremely narrow precedent for application in future cases." (*Id*. at p. 500.)

Courts following *Mansell* have been similarly cautious in determining whether the balance of public policy concerns justifies application of estoppel against the government. (See, e.g., *West Washington Properties, LLC v. Department of Transportation, supra,* 210 Cal.App.4th at pp. 1148-1149 [Caltrans's inaction in enforcing an outdoor advertising restriction not estoppel to subsequent enforcement]; *Smith v. County of Santa Barbara* (1992) 7 Cal.App.4th 770, 773, 775-776 [estoppel did not apply against county which mistakenly issued a permit in reliance upon which plaintiff invested substantial sums]; *Seymour v. State of California* (1984) 156 Cal.App.3d 200, 202, 203-205 [refusing to apply estoppel against the state where plaintiff invested substantial sums in reliance on oral agreement]; *City of Fresno v. California Highway Com.* (1981) 118 Cal.App.3d 687, 697-698 [refusing to apply estoppel against state to enforce agreement to construct freeway].)

The facts here do not support estoppel. First, Provider has not shown that the elements of estoppel were met. Provider at all times had available to it access to the law and to the terms of the Contract, which make it clear that Day Care services are available only to persons who are pregnant, post-partum, or EPSDT-eligible.

Further, both the regulations and the Contract should have made it clear to Provider that Department could seek reimbursement of sums erroneously paid on Provider's claims. It is true that Department's (and Health Services') delay of several years in discovering the erroneous reimbursement of ineligible claims to Provider resulted in Provider providing additional services for which it was not entitled to reimbursement. However, the facts do not support a conclusion of "actual or constructive

fraud on the part of the party to be estopped." (*City of Long Beach v. Mansell*, *supra*, 3 Cal.3d at p. 489.)

The excluded evidence shows that Department told Provider it would reimburse for Day Care services to Minor Consent beneficiaries, that it reimbursed Provider for a number of years for services falling outside the Contract's limitations, and that Provider's reliance on this conduct resulted in financial loss. These representations and actions are insufficient to tip the estoppel balance in favor of Provider.

Even if the elements of estoppel are met, we consider whether applying estoppel against a governmental entity would be contrary to public policy and whether the ruling would create a broad precedent. Allowing parties who contract with the government to avoid the terms of their contracts on the ground they did not read and understand the contracts and were misled as to the terms of those contracts could have a significant negative effect on the public interest. Moreover, applying estoppel here would require the Department to use monies from the State General Fund for services in a manner prohibited by state law. (See Welf. & Inst. Code, § 14132.905 [Day Care services "shall be provided only to alcohol- and drug-exposed pregnant women and women in the postpartum period, or as required by federal law"].) Estoppel would thus be against public policy and would establish a broad precedent.

As in *Seymour v. State of California*, *supra*, 156 Cal.App.3d 200, Provider has cited "no case where an estoppel has been invoked against a government entity in a commercial setting so as to require it to make payments of public funds which it had not legally committed itself to make. The reasons for the lack of supporting authority are obvious; '[T]he doctrine of estoppel is not available to "'defeat the effective operation of a policy adopted to protect the public.'" And, "no court has expressly invoked principles of estoppel to contravene directly or indirectly any statutory or constitutional limitations."' [Citation.]" (*Id*. at pp. 204-205, fn. omitted.)

Accordingly, we conclude as a matter of policy that equitable estoppel is not available to Provider as an affirmative defense to Department's cross-complaint. The trial court did not err in granting summary judgment in favor of Department.

DISPOSITION

The judgment is affirmed. Department is to recover its costs on appeal.

STROBEL, J.*

We concur:

ZELON, Acting P. J.

SEGAL, J.

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* Judge of the Los Angeles Superior Court, assigned by the Chief Justice pursuant to article VI, section 6 of the California Constitution.